HEALTH AND SENIOR SERVICES

DIVISION OF HEALTH CARE QUALITY AND OVERSIGHT

Hospital Licensing Standards
Patient Payment Arrangements
Proposed Amendments: N.J.A.C. 8:43G-5.2 and 12.7

Authorized By:	Clifton R. Lacy, M.D., Commissioner, Department of Health and Senior Services (with the approval of the Health Care Administration Board).
Authority:	N.J.S.A. 26:2H-18.63e
Calendar Reference:	Please see Summary below for statement of exception of the rulemaking calendar requirements.
Proposal Number:	PRN 2003-429

Submit comments by December 19, 2003 to:

John A. Calabria, Director
Certificate of Need and Acute Care Licensure Program
New Jersey Department of Health and Senior Services
P.O. Box 360
Trenton, New Jersey 08625-0360

The agency proposal follows:

Summary

The Department of Health and Senior Services (the Department) is proposing to amend the Hospital Licensing Standards at N.J.A.C. 8:43G-5.2 and 12.7, respectively, sections within those subchapters dealing with administrative hospital-wide services and emergency department services. These amendments permit hospitals to inquire about patients' health insurance coverage and/or eligibility for benefits related to health care services. The proposed amendments in the hospital licensing standards change hospital practices by allowing them to conclude a payment

arrangement with those patients seeking non-emergency or elective health care services, or with the patient's authorized representative acting on behalf of the patient, who fail to produce proof of health insurance or sworn financial information sufficient to determine eligibility for health care benefits, or with those who are determined to be ineligible for health care benefits.

The amendments that follow are intended to benefit hospitals in their attempts to recover payment from patients seeking non-emergency or elective health care services who are without any source of third party payment. The proposed amendments are made pursuant to P.L. 2001, c. 296, codified at N.J.S.A. 26:2H-18.63e. The primary goal of this legislation was to enable hospitals to establish a written agreement with the self-pay patient prior to the initiation of treatment. It is expected that this contract will facilitate self-pay patients to remit charges to the hospital in a more expedient manner.

As a corollary to this matter, the Department also looked at the provision of non-emergency or elective treatment to patients who receive their health care benefits under a managed care organization and examined the problems inherent in that reimbursement scheme. Typically, managed care organizations offer coverage for health care services provided by a facility within the insured's plan of network providers. When hospitals elect to transfer a patient under a managed care health plan for non-emergency or elective services, the receiving hospital must be within that insured's provider network, or the plan may refuse to reimburse that individual for the services rendered.

The amendments seek to benefit both hospitals and insureds. Hospitals that treat patients within their contracted service agreements with managed care organizations are more likely to receive payment for services. Similarly, patients will avoid being charged self-pay rates by hospitals resulting from non-coverage determinations if treated by a facility within their plan's network of providers.

The subject matter of the amendments is contained in two sections in the subchapters pertaining to administrative hospital-wide services and emergency department services, which fall under the purview of the hospital licensing standards. In so far as possible, the language has been revised, added to, and deleted wherever necessary for greater clarity and consistency between the subchapters.

The major amendments to the rules are summarized below:

The amendments to N.J.A.C. 8:43G-5.2(b) and 12.7(p) add, delete, and modify language to achieve greater clarity and consistency between the administrative hospital-wide and the emergency department services provisions.

Proposed N.J.A.C. 8:43G-5.2(b)1 and 12.7(p)1 adds language to clarify the hospital's responsibilities for transfers pursuant to Federal Emergency Medical Treatment and Active Labor Act, 42 U.S.C. §1395dd, (EMTALA) and the rules pursuant thereto at 42 C.F.R. 489.40 & 489.24 and N.J.A.C. 8:43G-12.

The amendments at N.J.A.C. 8:43G-5.2(b)1i and ii and 12.7(p)1i and ii clarify the hospital's responsibilities during transfer.

Proposed N.J.A.C. 8:43G-5.2(b)1iii. and 12.7(p)1iii adds language to refine the procedure for transferring persons with health insurance coverage for non-emergency or elective treatment. Specifically, the hospital intending to transfer a patient with health insurance coverage must make an appropriate referral to a facility within a provider network covered by that individual's health insurance plan.

Proposed N.J.A.C. 8:43G-5.2(c) adds language that prohibits hospitals from withholding or delaying medically necessary health care services, not just admission, to patients with health care insurance or benefits.

Proposed N.J.A.C. 8:43G-5.2(c)1 adds language that establishes the proofs and sworn financial information hospitals may require of patients before non-emergency or elective health care services are provided.

N.J.A.C. 8:43G-5.2(c)2 adds language that requires hospitals to provide medically necessary care to patients with proof of insurance or health care benefits or with sworn financial information sufficient for the hospital to determine eligibility for public health care benefits.

Proposed N.J.A.C. 8:43G-5.2(c)3 adds language that permits hospitals to make payment arrangements with patients seeking non-

emergency or elective procedures who fail to submit proofs or eligibility information pursuant to N.J.A.C. 8:43G-5.2(c)1.

Proposed N.J.A.C. 8:43G-5.2(c)3i adds language that defines a payment arrangement between a hospital and a prospective patient. A payment arrangement is an agreement between a patient seeking non-emergency or elective treatment who does not possess proof of health insurance or other health care benefits or eligibility information for public health care assistance and a hospital, in which the patient promises to pay for health care services and which also may require the patient to provide some form of guaranty prior to such services being rendered.

Proposed N.J.A.C. 8:43G-5.2(c)4 adds language regarding the hospital's duty to evaluate and treat emergency medical conditions and render post-discharge care, pursuant to EMTALA at 42 U.S.C. §1395dd and the rules established pursuant thereto at 42 C.F.R. 489.40 and 489.24 (N.J.A.C. 8:43G-12).

Proposed N.J.A.C. 8:43G-5.2(c)5 adds language preventing hospitals from discriminating in the care provided to persons without health insurance or benefits coverage.

Because a 60-day comment period has been provided on this notice of proposal, this notice is excepted from the rulemaking calendar requirement pursuant to N.J.A.C. 1:30-3.3(a)5.

Social Impact

The Department's licensing standards establish the minimum standards of care for all New Jersey licensed health care facilities. The proposed patient payment amendments reflect a commitment by the Department to be responsive to the emergent financial concerns of health care organizations and the average person's ability to pay for health care coverage and services. In addition, these amendments demonstrate the Department's dedication to preserving the quality of and access to health care services in the State.

The Department anticipates that the social impact may not be universally favorable. Persons who receive health care benefits under a managed care organization will most likely benefit from the requirement that hospitals transfer patients to facilities within the patient's insurance

plan network of providers. However, others who lack health care coverage, or proof thereof, may feel their privacy is being intruded upon. Persons without such proofs will be subject to the financial scrutiny of the hospital.

Furthermore, it is also possible that a person may feel unduly pressured to sign a payment contract when the receipt of medically necessary health care services is contingent upon entering into a binding agreement with the hospital. Understandably, some individuals may be anxious under the stress and uncertainty from a health care concern at the time that services for a non-emergency or elective procedure are sought.

Economic Impact

The proposed amendments will have a beneficial impact upon the health care industry, as hospitals are expected to avoid collections problems and litigation from self-pay patients by having a signed payment agreement before health care services are rendered, and patients will only be transferred for non-emergency or elective services to facilities that are covered under their managed care organization's health benefits plan. Because patients will be required to produce their insurance or benefits cards or proof of financial eligibility for public health benefits upon arrival at the hospital before non-emergency or elective procedures may be performed, it is expected that some patients may not be scheduled for treatment until such proof of coverage can be established with the hospital, or until the patient is able to provide sufficient sworn financial information indicating eligibility for public health care benefits. In the alternative, any anticipated delays in care created by the lack of such proofs are likely to be avoided by establishing a payment arrangement at the point of contact. Furthermore, those patients who seek non-emergency or elective treatment at an out-of-network hospital will benefit by avoiding liability for out of pocket expenses because the hospital is required to refer or transfer those patients to an in-network health care facility where their benefits will be effective.

Federal Standards Analysis

Federal law clearly intends that hospitals provide only those health care services necessary to stabilize an individual with an emergency medical condition. It does not appear that Federal law requires hospitals to provide any treatment for a condition that is determined not to be an

emergency medical condition. The State law does not mimic the language of the Federal law. However, while EMTALA (42 U.S.C. §1395dd and 42 C.F.R. 489.20 and 489.24) refers only to the provision of emergency care, the State law does not (N.J.S.A. 26:2H-18.64). Current State law does not limit its language regarding the provision of "charity" care to emergency services. Rather, the law indicates that hospitals are not permitted to deny any admission or appropriate service on the basis of ability to obtain payment for the services rendered. The implication has been for quite some time that more than emergency services are to be provided.

Jobs Impact

The proposed amendments will not result in any loss of jobs in the health care industry, although they may create some moderate increase in the workload of the hospital finance department. There is no anticipated impact on jobs for the public at large in the State of New Jersey.

Agriculture Industry Impact

The proposed amendments will have no impact on the agriculture industry.

Regulatory Flexibility Statement

The proposed amendments affect New Jersey hospitals, all of which employ well over 100 full-time employees. Thus, they are not defined as small businesses within the definition of that term, as set forth in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., and no regulatory flexibility analysis is necessary.

Smart Growth Impact

The proposed amendments will have no impact upon the achievement of smart growth and implementation of the State Development and Redevelopment Plan.

Full Text of the proposal follows (additions indicated in boldface and underlined **thus;** deletions indicated in brackets [thus]:

SUBCHAPTER 5. ADMINISTRATIVE AND HOSPITAL-WIDE SERVICES

8:43G-5.2 Administrative and hospital-wide policies and procedures

(a) (No change.)

(b) A [patient] **hospital** shall [be] transfer[red] **a patient** to another hospital only**:** for a valid medical reason[,]**;** [in order] to comply with other applicable laws or Department rules[,]**;** to comply with clearly expressed and documented patient choice[,]**;** or [in] to conform[ance] with the New Jersey Advance Directives for Health Care Act. [The] **A valid medical reason includes the** hospital's inability to care for the patient [shall be considered a valid medical reason].

1. A hospital shall transfer a patient in accordance with the Federal Emergency Medical Treatment and Active Labor Act at 42 U.S.C. §1395dd, and rules promulgated pursuant thereto at 42 C.F.R. 489.20 and 489.24, and State rules regarding evaluation and treatment of emergency medical conditions set forth at N.J.A.C. 8:43G-12, and in accordance with the following procedures:

i. The sending hospital shall [receive] **obtain** approval **for the** transfer from a physician and the receiving hospital before transferring the patient**; and**

ii. [Documentation for the transfer] **The sending hospital** shall [be sent with the patient, with] **send the following documentation with the patient to the receiving hospital and retain** a copy or summary **thereof** [maintained by the transferring hospital]. This documentation shall include, at least:

[1.] **(1)** The informed consent of the patient or responsible individual, in accordance with State law;

[2.] **(2)** The reason for the transfer;

[3.] **(3)** The signature of the physician who ordered the transfer;

[4.] **(4)** Patient information collected by the sending hospital, as specified at N.J.A.C. 8:43G-15.2(e);

[5.] **(5)** The name of the contact person at the receiving hospital; and

[6.] **(6)** A copy of the patient's advance directive where available or notice that the individual has informed the sending hospital of the existence of an advance directive.

iii. The sending hospital shall meet the additional provisions set forth below if the patient to be transferred requires non-emergency or elective treatment and is insured under a managed care plan, as defined at N.J.S.A. 26:2S-2, or covered under a group health plan, as defined by Federal law at 29 C.F.R. 2590.701-2, that would otherwise meet the definition of a managed care plan, but for it not being a health benefits plan as defined at N.J.S.A. 26:2S-2. "Non-emergency or elective health care service" means a procedure to treat any condition other than an "emergency" as defined at N.J.A.C. 8:38-1.2.

(1) The sending hospital does not participate in the network applicable to the patient's managed care plan or group health plan;

(2) The patient's coverage does not include out-of-network benefits; and

(3) The sending hospital determines prior to transfer that the receiving hospital participates in the network applicable to the patient's managed care plan or group health plan. The sending hospital shall retain a record of these non-coverage determinations.

(c) The hospital shall not deny admission **and/or medically necessary health care services** to patients on the basis of their ability to pay

.

1. Notwithstanding (c) above, prior to admitting and/or rendering health care services to a person seeking non-emergency or elective health care services, the hospital may require the person seeking medical services provide either:

i. Proof of benefits or coverage under a health benefits plan, as defined at N.J.S.A. 26:2S-2, or a group health plan, as defined at 29 C.F.R. 2590.701-2, for the services sought. The above-referenced proofs shall include a health insurance benefits card or a Medicaid or Family Care benefits card issued by the State of New Jersey; or

ii. Sworn personal and financial information sufficient for the hospital to determine as soon as possible, but no later than within 10 working days of submission, a person's eligibility for charity care or reduced-charge charity care, in accordance with the provisions of section 10 of P.L. 1992, c.160 (as codified, N.J.S.A. 26:2H-18.60) and pursuant to N.J.S.A. 10:52-11. Once it has deemed an individual eligible for charity care benefits, a hospital shall not require additional proofs from a person seeking health care services during a valid period of eligibility.

2. A hospital shall render medically necessary care to persons who provide documentation as required under (c)1i or ii above.

3. A hospital may conclude a payment arrangement with a person, or that person's authorized representative, who seeks non-emergency or elective health care services at the hospital, subject to the conditions set forth below:

i. A payment arrangement shall be an agreement between a hospital and a person, or that person's authorized representative, who seeks non-emergency or elective health care services at the hospital, in which the intended recipient of these services, or that recipient's authorized representative, promises to remit payment to the hospital for services rendered. A payment arrangement may require a form of guaranty that the charges for the treatment services will be paid, but the hospital shall not limit the method of acceptable guaranty to a single method, nor shall a hospital require collateral or security in order for services to be rendered.

ii. A hospital may conclude a payment arrangement if the hospital determines that based on the proofs submitted as required under (c)1 above:

(1) The person does not have benefits or coverage under a health benefits plan or group health plan;

(2) The person is not otherwise eligible for charity care or reduced charge charity care; or

(3) The person is a member of a managed care plan, as defined at N.J.S.A. 26:2S-2, or a group health plan that meets the definition of a managed care plan (but for not being a health benefits plan), and the following conditions exist:

(A) The plan does not provide coverage for the services being sought if the hospital does not participate in the network applicable to the person's health benefits plan or group health plan;

(B) The plan does not provide out-of-network benefits; and

(C) The hospital does not participate in that plan.

iii. A hospital may conclude a payment arrangement if the person is unable or unwilling to provide either:

(1) Proof of insurance or coverage under a health benefits plan or group health plan, as described in (c)1 above; or

(2) Sworn financial information sufficient for the hospital to determine whether the person is eligible for charity care or reduced charge charity care, as described in (c)1 above.

4. Nothing in (c)1 or 2 above shall be construed to reduce or eliminate a hospital's obligation to comply with the Federal Emergency Medical Treatment and Active Labor Act, and rules promulgated pursuant thereto at 42 C.F.R. 489.20 and 489.24, and State rules regarding evaluation and treatment of emergency medical conditions set forth at N.J.A.C. 8:43G-12, or the rules pertaining to post-discharge care at N.J.A.C. 8:43G-12.7(o).

5. The hospital shall provide health care services to those meeting the criteria in (c)1 or 2 above consistent with the manner applied to persons who demonstrate proof of health insurance

coverage or eligibility in a health benefits plan or charity care or reduced-charge charity care program.

(d) - (m) (No change.)

SUBCHAPTER 12. EMERGENCY DEPARTMENT AND TRAUMA SERVICES

8:43G-12.7 Emergency department patient services

(a) - (e) (No change.)

(f) [If it is] **An emergency department may, after a medical screening examination** determine[d]**s** that **a patient does not have** an emergency medical condition [does not exist], [the patient shall] either [be] treat[ed] **the patient** in the emergency department, or [shall be] refer[red] the patient to an appropriate health care facility or provider **in accordance with (p) below**.[; and the patient] **The emergency department** shall [be] discharge[d] **the patient** in accordance with (n) below.

1. A hospital shall comply with N.J.A.C. 8:43G-5.2(c) for the provision of health care services in the emergency department, or for the provision of emergency medical treatment within another department of the hospital.

(g) - (m) (No change.)

(n) Upon discharge from the emergency department following a medical screening examination and/or treatment, the **hospital shall provide the** patient or his or her representative [shall be given] **with** written instructions and an oral explanation of those instructions. [Documentation of] **Hospital personnel shall document legibly in the medical record the specific** instructions **given to the patient or representative,** the name of the [physician] **qualified medical personnel** who ordered the instructions, the name of the person who gave the oral explanation, and the name of the person receiving the instructions [shall be entered legibly in the medical record].

(o) (No change.)

(p) [A] **An emergency department shall transfer a** patient [shall be transferred] to another health care facility only: for a valid medical reason [or by patient choice] **; to comply with other applicable laws or Department rules; to comply with clearly expressed and documented patient choice; or to conform with the New Jersey Advance Directive for Health Care Act, N.J.S.A. 26:2H-53 et seq. A valid medical reason includes the hospital's inability to care for the patient.**

1. An emergency department shall transfer a patient in accordance with the Federal Emergency Medical Treatment and Active Labor Act at 42 U.S.C. §1395dd, and rules promulgated pursuant thereto at 42 C.F.R. 489.20 and 489.24, and State rules regarding evaluation and treatment of emergency medical conditions set forth in this subchapter and in accordance with the following procedures:

i. The sending [hospital] **emergency department** shall [receive] **obtain** approval **for the transfer** from a physician and the receiving hospital before transferring the patient**; and**

ii. [Documentation for the transfer] **The sending emergency department** shall [be sent with the patient, with] **send the following documentation with the patient to the receiving hospital** [,] **and retain** a copy or summary **thereof** [maintained by the transferring hospital]. **This documentation shall include, at least:**

[1.] **(1)** [Informed] **The informed** consent of the patient or responsible individual, in accordance with State law;

[2.] **(2)** [Reason] **The reason** for the transfer;

[3.] **(3)** [Signature] **The signature** of the physician who ordered the transfer;

[4.] **(4)** Condition of the patient upon transfer;

[5.] **(5)** Patient information collected by the sending emergency department, including x-ray films or written interpretation by a radiologist; [and]

[6.] **(6)** [Name] **The name** of the contact person at the receiving hospital**; and**

(7) A copy of the patient's advance directive where available or notice that the individual has informed the sending hospital of the existence of an advance directive.

iii. The sending emergency department shall meet the additional provisions set forth below if the patient to be transferred requires non-emergency or elective treatment and is insured under a managed care plan, as defined at N.J.S.A. 26:2S-2, or covered under a group health plan, as defined by federal law at 29 C.F.R. 2590.701-2, that would otherwise meet the definition of a managed care plan, but for it not being a health benefits plan as defined at N.J.S.A. 26:2S-2. "Non-emergency or elective health care service" means a procedure to treat any condition other than an "emergency" as defined at N.J.A.C. 8:38G-1.2.

(1) The sending hospital does not participate in the network applicable to the managed care plan or group health plan;

(2) The patient's coverage does not include out-of-network benefits; and

(3) The sending emergency department determines prior to transfer that the receiving health care facility participates in the network applicable to the patient's managed care plan or group health plan.

(q) - (z) (No change.)